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MEMORANDUM

To: Individuals Who Commented on Regulation 11-14
Person-Centered Medical Homes (PCMH)

From: Roderick L. Bremby, Commissioner
Department of Social Services

Date: March 25, 2014

Re: Response to Comments on Regulation 11-14 – PCMH

The Department of Social Services ("the Department") responds to public comments received concerning the proposed regulation referenced above. The Notice of Intent for this regulation was published in the Connecticut Law Journal on January 17, 2012. A copy of the regulation with revisions based on public comments and the Department's other revisions is attached.

1. Comment Regarding Regulatory Procedure

Comment: Will the Department operate under proposed PCMH regulations pending final approval of the regulation?

Response: Yes. Section 17b-263c(b) of the Connecticut General Statutes authorizes the Department to establish and operate a medical homes program (such as the PCMH program) using policies and procedures in draft regulation form pending final adoption of the regulation, based on the procedures in Conn. Gen. Stat. §§ 17b-263c and 17b-10.

2. Comments Regarding Prospective Non-Performance-Based Per Member Per Month Payments

Comments: Expand existing language authorizing the Department to "consider establishment of PMPM payments" by adding: (1) a definition of "'Prospective non-performance-based per member per month payment system' or 'Prospective non-performance-based PMPM payment system' means a monthly, non-performance-based payment made prospectively to a person-centered medical home for care coordination services provided both in relation to and not in relation to patient office visits"; (2) language in sections 17b-262-931(d), 17b-262-932(b)(2)(E) and 17b-262-933(a) as follows "The Department may replace the participation fee differential payments…with a prospective non-performance-based PMPM payment system"; and (3) language in the Statement of Purpose clarifying that eligible PCMH practices could be eligible for higher reimbursements or prospective non-performance-based per member per month payments.

Response: The Department agrees with the purpose of these comments. Accordingly, the Department made revisions to clarify that, on or after January 1, 2014, the Department may choose between using advance per member payments (a similar term to non-performance-based per member-per-month payments) or enhanced fee-for-service payments. Specifically, the Department has: (1) added a definition similar to the one proposed in the comment using the term "advance per member payment", (2) added language in redesignated section 17b-262-932(b) to provide that the department may choose between offering enhanced fee-for-service payments or advance per member payments, with additional language in section 17b-262-932 clarifying the scope and mechanics of such payments, and (3) broadened the Statement of Purpose to provide that eligible PCMH practices may receive "enhanced payments" rather than specifying the type of available payment method.

3. Section 17b-262-928(c)(4) [Formerly Section 17b-262-928(e)(5)]

Comment: Reduce the requirement for all practitioners for whom the PCMH seeks enhanced payments to devote 51% rather than 60% of their time to delivering primary care services.

Response: The Department declines to make the requested revision because it would undermine the focus of the PCMH program on primary care. Recognizing the need for flexibility, the Department set 60% as the standard, rather than the current NCQA standard of 75%. The 60% threshold is necessary to ensure that a practice may receive PCMH enhanced payments only for services provided by primary care practitioners with a predominant focus on primary care.

4. Section 17b-262-928(c)(4) [Formerly Section 17b-262-928(e)(5)]

Comment: Ensure that the calculation of determining whether a practitioner devotes at least 60% of their time to delivering primary care services does not mean that they need to devote at least 60% of their time delivering primary care services at one specific site.

Response: The language in this subdivision is very broad and is not limited to the practitioner's time at any specific site. Instead, this language simply ensures that in total, the practitioner spends at least 60% of the practitioner's total clinical time (across all payers and in all practice settings). The Department has further clarified this language to avoid any ambiguity.

5. Former Section 17b-262-928(d) [Subsection now deleted]

Comment: Revise language as follows: "(d) If a practice maintains multiple locations and not all of those locations [are qualified] qualify under the [same NCQA Glide Path phases] DSS PCMH Initiative and/or Glide Path Application Process, the practice may be deemed, [within the department's sole discretion] based on specific criteria established by the department, to qualify as a [NCQA] PCMH practice if all locations follow the same practices and procedures."

Response: The Department deleted the entire subsection that was the subject of the comment to ensure that the National Committee for Quality Assurance (NCQA) or other relevant PCMH standard-setting authority requirements apply uniformly to each practice site because NCQA

requires that each practice site must separately comply with its PCMH standards. The only exceptions are specified non-standard practices (described in the next paragraph). In general, a multi-site practice can accelerate the process of attaining PCMH status for all of its practice sites by following the same procedures designed to comply with PCMH standards across all of its practice sites.

The Department revised the regulation so that specified non-standard practice settings not currently eligible for NCQA PCMH recognition, at the department's discretion, may seek Glide Path status, PCMH status, or PCMH accreditation, as applicable, provided they meet various requirements, including a relationship with a parent entity that ensures patients receive the full spectrum of services available in a practice with PCMH or Glide Path status or a provider that seeks or has obtained PCMH accreditation.

6. Section 17b-262-929(b)(2)

Comment: Revise language as follows: "In order to qualify for Glide Path, a practice shall… (2) demonstrate that it has initiated activities that indicate its intention to become a PCMH by providing the department with its NCQA Survey Tool Scores and a work plan documenting the steps the practice has taken and will take toward [PCMH recognition based on NCQA Level 2 or NCQA Level 3 Standards] accomplishing the tasks associated with Phase 1 and Phase 2 of the Glide Path Application and/or provide documentation of such activities as described in subsections (e) and (f)."

Response: The Department declines to make the requested revisions because they would undermine the purpose of the Glide Path to encourage practices to seek and attain PCMH status within the Glide Path time limits. The gap analysis and work plan that each practice must submit as part of the Glide Path application outline steps the practice will take to achieve full PCMH status within the applicable time period. The revisions requested in the comment would limit the work plan to showing only those steps needed to comply with the Glide Path minimum standards, which are merely intended to guide practices towards PCMH status, not as a substitute for PCMH standards.

7. Section 17b-262-929(b)(7) [Formerly Section 17b-262-929(b)(4)]

Comment: Do not require practices to give the Department read-only access to their NCQA PCMH applications, at least not at the beginning of Glide Path. In the alternative, potentially require practices to submit updated self-assessment scores at the beginning of each Glide Path phase and share read-only access to the NCQA PCMH application as part of Glide Path Phase 3 documentation.

Response: The Department has revised the language simply to require practices to provide the Department with access to the practice's staff, facilities and documents involved in seeking PCMH status. That more general language will ensure that the Department has access to the various types of documents that are necessary to evaluate the practice's progress towards completing the requirements for NCQA PCMH recognition as each practice moves through Glide Path.

8. Section 17b-262-929(d)

Comment: Provide Glide Path reimbursement effective January 1, 2012 for practices that have been working towards NCQA PCMH recognition during calendar year 2011.

Response: In order to recognize work on Glide Path that had been done before January 1, 2012 while also balancing the need for timely documentation of such work, subsection (d) of 17b-262-929 now provides that for a practice that submitted a complete Glide Path application on or before April 30, 2012, the effective date of Glide Path is the first day of the month prior to the month in which the application was submitted (but no earlier than January 1, 2012, because that was the first day that the PCMH program was implemented).

9. Section 17b-262-931(a) [Formerly Section 17b-262-930(a)]

Comment: How will the Department attribute newborns and others with no claims history for a practice to a practice?

Response: Members attribute themselves to a practice by selecting the practice as their primary care provider or by going to the practice. The process of attribution begins with a member's selection of a practice (which can happen before any visits occur) or the member's first visit to a practice, as adjusted based on future visits. The Department has simplified the language in redesignated section 17b-262-931(a) to provide that members shall be attributed to each practice based on their selection or visit history. While there will be some delay in attributing patients without prior claims history (if they do not select a provider), those patients will be attributed in the next attribution cycle after they start seeing providers.

10. Section 17b-262-931(a) [Formerly Section 17b-262-930(a)(1) and (3)]

Comment: Add language to clarify that (1) a patient with a visit history at more than one practice will be assigned to the practice where the patient most recently received the majority of primary care services and (2) no default assignments would occur until the patient has a claims history.

Response: The Department deleted all of the former subdivisions of redesignated subsection 17b-262-931(a) and simplified the subsection to provide only that members shall be attributed to each practice based on their selection or visit history. Simplicity in this section is necessary to ensure there is sufficient flexibility to continue refining the attribution methodology, not hard-coding specific policy details in a regulation. Accordingly, the requested revisions are unnecessary.

11. Section 17b-262-931 [Formerly Section 17b-262-930]

Comment: Add a new subsection (c) to redesignated section 17b-262-931, as follows: "The department may in the alternative adopt an enrollment system whereby, rather than assigning all recipients based on claims history, it invites and allows all enrollees to choose a PCMH, with those not responding with a choice of PCMH by a certain date subject to being assigned to a

PCMH based on their claims history. In that event, the department will provide a monthly roster of all primary care patients with or attributed to a practice."

Response: The Department partially agrees with the intent of the comment. Accordingly, the Department revised the language to provide that members will be attributed to a practice based on their selection or visit history. Both systems respect the member's choice in selecting or seeing the provider of their choice. The Department has simplified the attribution language to preserve the flexibility to adjust and refine the operational details of the attribution process. See also response to Comment 8, above.

12. Summary of the Department's Other Revisions

In order to comply with federal requirements and state budget appropriation changes associated with Public Ac 12-1 of the December 2012 special session, as well as to improve the operation of the program and clarify the regulations, the Department made various revisions reflected in the attached copy of the proposed regulation. Some of the changes include:

PCMH Status Requirements: The Department revised section 17b-262-928 to: (1) clarify PCMH status requirements and the rules for certain non-standard practice settings to be potentially eligible for PCMH status; (2) clarify the effective date for PCMH status; (3) clarify the rules for nurse practitioners, physician assistants and community preceptors as primary care practitioners for whom a practice seeks PCMH status payments; (4) clarify the Department's authority to monitor and remedy the performance of practices with PCMH status; and (5) clarify the rules regarding expiration and renewal of a practice's previously obtained NCQA PCMH recognition.

Glide Path Requirements: The Department revised section 17b-262-929 to: (1) clarify the eligibility requirements for Glide Path participation, including rules for certain non-standard practice settings; (2) clarify the effective date of Glide Path participation; (3) clarify the time limits and extension procedures for Glide Path phases; and (4) clarify the Department's authority to monitor and remedy Glide Path practices' performance.

PCHM Accreditation Requirements: Because the legislative budget changes adopted as part of Public Act 12-1 of the December 2012 special session made FQHCs no longer eligible for PCMH status or Glide Path payments effective January 1, 2013, the Department created a new section 17b-262-930 to enable FQHCs to continue participating in the PCMH program using either The Joint Commission's PCMH standards or NCQA Level 1, 2, or 3 PCMH recognition. In addition, outpatient hospital clinics that choose to pursue The Joint Commission PCMH certification rather than NCQA PCMH recognition may do so under this section to receive non-financial technical assistance and recognition. This section clarifies the requirements for non-financial support and recognition provided through the PCMH accreditation option.

Requirements for Enhanced Payments: For clarity, the Department consolidated most of the language previously contained in sections 17b-262-932 and 17b-262-933 into section 17b-262-933. The Department also clarified: (1) claim submission requirements for enhanced fee-for-service payments and (2) measurement year, performance tracking methodology and practice information submission requirements for performance-based supplemental payments.